HUMAN IMMUNODEFICIENCY VIRUS (HIV) ANTIBODY TEST

CONSENT FORM (ORASURE)

All Other Health Care Settings
(STD, TB, DTC, PN, FP, CHC, etc.)

This is not a test for AIDS. This is a test for antibodies to the virus named HIV. A counselor has told me what a negative or positive test result means. On my return visit, a counselor will explain my test results to me.

I understand that knowing my HIV result is important to my health. I understand that by testing confidentially at this clinic, I will sign my name, address and phone number on this form. This is the best way for me to enter into treatment and to learn of other available services. It is also a way for someone to reach me if I cannot return for my test results.

I will get a code number. This number will be on the consent form, lab slip and specimen tube. The lab slip and specimen tube will be sent to the State laboratory where the test will be done. My code number, not my name, will be on the lab slip and the specimen tube. All records are kept under lock and key.

Should I test positive this information will be reported to the New Jersey Department of Health and Senior Services as required by law. Any other release of this information will require my written consent or a court order or subpoena. I have read or someone has read this form to me. All of my questions have been answered.

_____	_____
(Signature of Witness)	(Signature of Client)
_____	_____
(Code Number)	(Street Address)
_____	_____
(Date)	(City and State)
_____	_____
(Name of D/A Treatment Clinic)	(Phone Number)